



PATIENT REGISTRATION FORM

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information:

Name: _____ Date: _____

Last Name

First Name

M.I.

Mailing Address: _____

City: _____ State _____ Zip: _____

Social Security #: _____ Home Phone: _____

Email Address: _____ Cell Phone: _____

Sex: Male Female Age: _____ Birthdate: _____ Marital Status: _____

Patient Employed by: _____ Occupation: _____

Business Address: _____ Bus. Phone _____

Emergency contact: _____ Phone: _____

Whom may we thank for referring you?: _____

Primary Insurance Information:

Policy Holder: _____

Last Name

First Name

M.I.

Relation to Patient: _____ Birthdate: _____ Soc. Sec. #: _____

Address (If different from Patient's): _____

_____ Home Phone: _____

City: _____ State _____ Zip: _____

Policy Holder Employed by: _____ Occupation: _____

Business Address: _____ Bus. Phone: _____

Insurance Company: _____

Phone#: _____ Group#: _____ Subscriber#: _____

Names of other dependents covered under this plan: _____

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Additional Dental Insurance:

Is patient covered by additional dental insurance: yes no

Subscriber Name: _____

Relation to Patient: _____ Birthdate _____

Address (If different from patient's): _____

Phone: _____ City: _____ State: _____ Zip: _____

Subscriber Employed by: _____ Bus. Phone: _____

Insurance Company: _____ Soc. Sec. #: _____

Phone#: _____ Group#: _____ Subscriber#: _____

Names of other dependents covered under this plan: _____

Dental History:

Reason for Today's Visit: _____

Date of last dental visit: _____

Former Dentist: _____ Date of last dental X-rays: _____

Address: _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Hot |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity When Biting |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Sores or Growths in Your Mouth |

How often do you floss? _____ How often do you brush? _____

Medical History:

Physician's Name: _____ Date of Last Visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine).
 yes no

Have you had any serious illnesses or operations? yes no if yes, describe _____

Have you ever had a blood transfusion? yes no if yes, give approximate dates _____

(Women) Are you pregnant? yes no Nursing? yes no Taking Birth Control pills? yes no

Have you ever been diagnosed with cancer? yes no If yes, what type? _____ Stage? _____

Chemotherapy? yes no If yes, when? _____ Radiation Treatments? yes no If yes, when? _____

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Check (✓) if you have or have had any of the following:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet/Ankle |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Headaches | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease | | |
| <input type="checkbox"/> Any other conditions for which we should be aware: _____ | | | |

MEDICATIONS

List medications you are currently taking:

ALLERGIES

AUTHORIZATION:

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize the dentist to perform a comprehensive examination and take the necessary radiographs to complete this examination.

Signature of Patient or Responsible Party

Date

**ALL PAYMENTS (INCLUDING COST SHARE) ARE DUE IN FULL AT TIME OF TREATMENT
UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.**